REPORTING METRICS FOR INTEGRATION OF PHYSICAL-BEHAVIORAL HEALTH CARE

MARISA DERMAN, MD, MSC (OMH)
M. ASHLEY HEALD, MA (UW)

OBJECTIVES FOR THIS WEBINAR

• Review goals/ standards
• Review mandatory activities
• Review metrics in detail
• Discuss data collection process
STANDARDS

- EVIDENCE BASED
- DEPRESSION CARE PRACTICES

(from workplan application page 65-66)

STANDARDS

Setting, Staffing and Supervision

- Designated staff (care manager) to support depression treatment.

- Care manager who participates in regularly scheduled, ongoing (e.g. weekly) caseload supervision with a psychiatrist who makes treatment recommendations for patients who are not improving.
STANDARDS

Setting, Staffing and Supervision

• Consulting psychiatrist available by phone or in person for ad hoc consultation to care manager and primary care providers.

• Consulting psychiatrist available to evaluate patient and make treatment recommendations, if needed.

STANDARDS

Patient Education

• Education about depression and treatment options provided to patients
STANDARDS

Treatment Planning and Delivery

- Treatments used are consistent with evidence based treatment guidelines for depression.
- Primary care provider makes or confirms diagnosis of depression, prescribes antidepressant medication, educates the patient about wellness, makes changes in treatment in consultation with care manager and/or consulting psychiatrist if patient is not improving.

STANDARDS

Treatment Planning and Delivery

- Patients receive follow-up by phone or in-person within two weeks of starting new medication or changing medication to evaluate for adherence and side effects.
- Patients receive proactive assistance with management of side effects.
STANDARDS

Treatment Planning and Delivery

• Activity scheduling (behavioral activation) provided by care manager as part of treatment.
• Evidence based counseling (such as problem solving therapy) offered, either as a primary treatment or adjunct to medication therapy.
• Referral to mental health or substance abuse specialty care, if needed.
• Evidence based depression care practices.

STANDARDS

Tracking Treatment Outcomes

• In person or phone follow up at least once every two weeks during the active phase of treatment to monitor adherence and response to treatment.
• In person or phone follow up at least once a month during the maintenance phase of treatment.
• Use of phone to reach patients who cannot make clinic appointments.
• Depressive symptoms monitored at each contact with a rating scale (eg PHQ-9) that quantifies treatment response.
• Staff and providers use a registry or other tracking system to follow patients and ensure that they don’t fall through the cracks.
STANDARDS

Treatment Based On Outcomes (Stepped Care)
- All treatment plans have a ‘shelf life’ of no more than 10 weeks (12 weeks for older adults).
- If the patient is not at least 50% improved at the end of 10 weeks, the treatment plan is changed.

Relapse Prevention
- Patients who are in remission complete a relapse prevention plan that is communicated to their primary care provider.

MANDATORY ACTIVITIES

- Technical assistance (innovator sites)
- Monthly webinars (PCMH grantee sites)
  ** these are viewable at: http://uwaims.org/nyscci/ipg/training_webinars.html
  http://uwaims.org/nyscci/pcmh/webinars.html

- Data reporting on metrics
METRICS

These metrics were chosen based on previous implementations of Collaborative Care

Indicators of how well clinics are implementing the elements necessary for successful integration

- Outpatient site staff care manager time (FTE equivalent) dedicated to chronic physical health management and to behavioral health care management.
- Number of adult patients per year from the outpatient site who received a PHQ-2 or a PHQ-9
- Number of patients from the outpatient site screening positive for depression who enrolled in physical-behavioral health care coordination program.
METRICS

- Number of patients screened positive from the outpatient site who were then diagnosed with depression (eliminates false positives on screen).
- Number of patients from the outpatient site whose PHQ-9 went from at >10 to <10 in 16 weeks or greater.
- Number of patients from the outpatient site referred for psychiatric consultation.
- Number of patients from the outpatient site still receiving medication and/or psychotherapy six (6) months after enrollment.

METRICS

- These metrics have been modified slightly
- To be more clear and to help focus data reporting
- Should be easier to track
- Please note what the denominators are for each variable - this will be visible in IPRO for the next data report
METRIC: DEPRESSION SCREENING

- **Numerator definition:** Number of adult patients per year from the outpatient site who received a PHQ-2 or a PHQ-9.
- **Denominator definition:** All patients from the outpatient site.

METRIC: PATIENTS ENROLLED IN PHYSICAL-BEHAVIORAL HEALTH PROGRAM

- **Numerator definition:** Number of patients from the outpatient site screening positive for depression who enrolled in physical-behavioral health care coordination program (**Collaborative Care Initiative**).
- **Denominator definition:** All patients from the outpatient site screened positive for depression.
METRIC: PATIENTS DIAGNOSED WITH DEPRESSION

- **Numerator definition:** Number of patients screened positive from the outpatient site who were then diagnosed with depression (eliminates false positives on screen).

- **Denominator definition:** All patients from the outpatient site screened positive for depression.

METRIC: PHQ-9 DECREASES BELOW 10 IN SIX MONTHS

- **Numerator definition:** Number of patients enrolled in the Collaborative Care Initiative whose PHQ-9 went from at >10 to <10 in 16 weeks or greater.

- **Denominator definition:** All patients enrolled in the Collaborative Care Initiative.
METRIC: ENROLLED PATIENTS W/PSYCHIATRIC CONSULT

**Numerator definition:** Number of patients enrolled in the Collaborative Care Initiative referred for psychiatric consultation*.

**Denominator definition:** All patients enrolled in the Collaborative Care Initiative.

METRIC: RECEIVING MEDS/ THERAPY AFTER SIX MONTHS

**Numerator definition:** Number of patients enrolled in the Collaborative Care Initiative still receiving medication and/or psychotherapy six (6) months after enrollment.

**Denominator definition:** All patients enrolled in the Collaborative Care Initiative.
In depth...

DOH IPRO SITE WITH INTEGRATION OF PHYSICAL-BEHAVIORAL HEALTH CARE METRICS

This refers to the New York State – Collaborative Care Initiative (NYS-CCI)
### Metrics Your EHR or Registry May Not Be Able to Calculate

The table below shows the measure name, definitions, numerator, and denominator for the number of patients receiving medication and/or psychotherapy 6 months after enrollment.

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td><strong>Numerator definition</strong>: Number of patients from the outpatient site still receiving medication and/or psychotherapy six (6) months after enrollment.</td>
<td>0</td>
<td>9999</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Denominator definition</strong>: All patients from the outpatient site with a depression diagnosis.</td>
<td>Unable to capture</td>
<td>To be implemented</td>
</tr>
</tbody>
</table>

The AHRQ measure identification number is 0.
### NUMBER OF PATIENTS RECEIVING MEDICATION AND/OR PSYCHOTHERAPY 6 MONTHS AFTER ENROLLMENT

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Values</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Implementation Status</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td>Numerator definition: Number of patients enrolled in the Collaborative Care Initiative still receiving medication and/or psychotherapy six (6) months after enrollment.</td>
<td>Numerator: 0</td>
<td>0</td>
<td>Unable to capture</td>
<td>AHRQ To be implemented</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denominator definition: All patients enrolled in the Collaborative Care Initiative.</td>
<td>Denominator: 9999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NUMBER OF PATIENTS STILL RECEIVING MEDICATION AND/OR PSYCHOTHERAPY 6 MONTHS AFTER ENROLLMENT

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Values</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Implementation Status</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td>Numerator definition: Number of patients enrolled in the Collaborative Care Initiative still receiving medication and/or psychotherapy six (6) months after enrollment.</td>
<td>Numerator: 0</td>
<td>0</td>
<td>Unable to capture</td>
<td>AHRQ To be implemented</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denominator definition: All patients enrolled in the Collaborative Care Initiative.</td>
<td>Denominator: 9999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* What is the point of this metric?*

= depression care, defined as psychotropic medication and/or psychotherapy
NUMBER OF PATIENTS STILL RECEIVING MEDICATION AND/OR PSYCHOTHERAPY 6 MONTHS AFTER ENROLLMENT

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definition</th>
<th>Numerator</th>
<th>Goal Rate</th>
<th>Measure Identification Number</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td><strong>Numerator definition:</strong> Number of patients enrolled in the Collaborative Care Initiative still receiving medication and/or psychotherapy six (6) months after enrollment.</td>
<td>0</td>
<td>Unable to capture</td>
<td>AHRQ</td>
<td>To be implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Denominator definition:</strong> All patients enrolled in the Collaborative Care Initiative.</td>
<td>9999</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• What is the point of this metric?
• Does DOH want to see a high percentage or a low percentage for this metric?

Site | Measure Name | Definition | Numerator | Goal Rate | Measure Identification Number | Data Source |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td><strong>Numerator definition:</strong> Number of patients enrolled in the Collaborative Care Initiative still receiving medication and/or psychotherapy six (6) months after enrollment.</td>
<td>0</td>
<td>Unable to capture</td>
<td>AHRQ</td>
<td>To be implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Denominator definition:</strong> All patients enrolled in the Collaborative Care Initiative.</td>
<td>9999</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• What is the point of this metric?
• Does DOH want to see a high percentage or a low percentage for this metric?
• Are you saying it’s good to keep patients on my caseload for a really long time?
NUMBER OF PATIENTS STILL RECEIVING MEDICATION AND/OR PSYCHOTHERAPY 6 MONTHS AFTER ENROLLMENT

- What is the point of this metric?
- Does DOH want to see a high percentage or a low percentage for this metric?
- Are you saying it's good to keep patients on my caseload for a really long time?
- How do I calculate this?

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Numerator definition</th>
<th>Denominator definition</th>
<th>Numerator</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Identification Number</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td>Number of patients enrolled in the Collaborative Care Initiative still receiving medication and/or psychotherapy six (6) months after enrollment.</td>
<td>All patients enrolled in the Collaborative Care Initiative.</td>
<td>0</td>
<td>0</td>
<td>Unable to capture</td>
<td>AHRQ</td>
<td>To be implemented</td>
</tr>
</tbody>
</table>

NUMBER OF PATIENTS WHOSE PHQ-9 WENT FROM >10 TO <10 IN 16 WEEKS OR GREATER

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Numerator definition</th>
<th>Denominator definition</th>
<th>Numerator</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Identification Number</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td>Number of patients from the outpatient site whose PHQ-9 went from at &gt;10 to &lt;10 in 16 weeks or greater.</td>
<td>All patients from the outpatient site with a depression diagnosis.</td>
<td>0</td>
<td>0</td>
<td>Improve by 10%</td>
<td>Aims Collaborative</td>
<td>To be implemented</td>
</tr>
<tr>
<td>Site</td>
<td>Measure Name</td>
<td>Definitions</td>
<td>Values</td>
<td>Rate</td>
<td>Goal Rate</td>
<td>Measure Information Needed</td>
<td>Data Source</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>--------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
<td>-----------</td>
<td>----------------------------</td>
<td>-------------</td>
<td></td>
</tr>
</tbody>
</table>
| Site Per Office of Mental Health | Number of patients enrolled in the Collaborative Care Initiative whose PHQ-9 went from >10 to <10 in 16 weeks or greater. | Numerator: 0  
Denominator: 0 | 0 | Improve by 10% | Arms Collaborative | To be implemented |

**What is the point of this metric?**
**NUMBER OF PATIENTS WHOSE PHQ-9 WENT FROM >10 TO <10 IN 16 WEEKS OR GREATER**

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Values</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Implementation Status</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td>Numerator definition: Number of patients enrolled in the Collaborative Care Initiative whose PHQ-9 went from at &gt;10 to &lt;10 in 16 weeks or greater.</td>
<td>Numerator: 0</td>
<td>0</td>
<td>Improve by 10%</td>
<td>Arms Collaborative</td>
<td>To be implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denominator definition: All patients enrolled in the Collaborative Care Initiative.</td>
<td>Denominator: 9999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- What is the point of this metric?

- What if my patient’s score goes from >10 to <10 in less than 16 weeks?
**NUMBER OF PATIENTS REFERRED FOR A PSYCHIATRIC CONSULTATION**

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Values</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Identification Number</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Office of Mental Health</td>
<td>Numerator definition: Number of patients referred for psychiatric consultation.</td>
<td></td>
<td>Numerator: 0</td>
<td>0</td>
<td>Improve by 10%</td>
<td>Aims Collaborative</td>
<td>To be implemented</td>
</tr>
</tbody>
</table>

Denominator definition: All patients from the outpatient site with a depression diagnosis.

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Values</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Identification Number</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Office of Mental Health</td>
<td>Numerator definition: Number of patients enrolled in the Collaborative Care Initiative referred for psychiatric consultation.</td>
<td></td>
<td>Numerator: 0</td>
<td>0</td>
<td>Improve by 10%</td>
<td>Aims Collaborative</td>
<td>To be implemented</td>
</tr>
</tbody>
</table>

Denominator definition: All patients enrolled in the Collaborative Care Initiative.

*A psychiatric consultation in Collaborative Care is different from a traditional consultation. It can occur between the Psychiatric Consultant and the Care Manager, the Psychiatric Consultant and the PCP, as well as the Psychiatric Consultant and the Patient. The Psychiatric Consultant supports the PCP and Care Manager in treating patients with behavioral health problems. He/she typically meets with the Care Manager weekly to review the treatment plan for patients who are new or who are not improving as expected. Psychiatric consultations are largely done via phone with the Care Manager (and sometimes the PCP), and typically involve the discussion of 4-6 patients. During a consultation, the Psychiatric Consultant may suggest treatment modifications for the PCP or Care Manager to consider, recommend that he/she see the patient for an in-person consultation, or suggest that the patient be referred to specialty mental health services. Direct consultations can be performed face-to-face or using tele-video equipment. Typically, less than 10% of patients should need direct consultation.*

- Why the long explanation?
How many patients should get referred for these psychiatric consultations?

- 50% minimum. Ideally, 75%.

- Of those referred for psychiatric consultation, how many patients should be seen by the psychiatrist directly?
NUMBER OF PATIENTS REFERRED FOR A PSYCHIATRIC CONSULTATION

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure Name</th>
<th>Definitions</th>
<th>Values</th>
<th>Rate</th>
<th>Goal Rate</th>
<th>Measure Identification Number</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Per Office of Mental Health</td>
<td><strong>Numerator definition:</strong> Number of patients enrolled in the Collaborative Care Initiative referred for psychiatric consultation.</td>
<td>Numerator: 0</td>
<td>0</td>
<td>Improve by 10%</td>
<td>0</td>
<td>To be implemented</td>
</tr>
<tr>
<td>Denominator definition: All patients enrolled in the Collaborative Care Initiative.</td>
<td>Denominator: 9999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- How many patients should get referred for these psychiatric consultations?
  - 50% minimum. Ideally, 75%
- Of those referred for psychiatric consultation, how many patients should be seen by the psychiatrist directly?
  - 10% or less (or not at all if you don’t have access to a psychiatrist for direct consultation or telemedicine.
- **How do I calculate this?**

STRATEGIES FOR DATA COLLECTION

- EHR
- Registry (C MTS or other)
- Spreadsheet
- Pencil & Paper
CMTS INFORMATION FOR PCMH GRANTEES CAN BE FOUND HERE:
• http://uwaims.org/nyscci/pcmh/CMTS.html

CMTS INFORMATION FOR INNOVATIVE PRACTICES CAN BE FOUND HERE:
• http://uwaims.org/nyscci/jpg/CMTS.html
CMTS REPORT ON THE 4 METRICS

CMTS Report of DOH Metrics - Mock up

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Total Enrollment (i)</th>
<th>Long Term PHQ Improvement</th>
<th>Psychiatric Consultation</th>
<th>Six-Month Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 1</td>
<td>76</td>
<td>0</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>133</td>
<td>0</td>
<td>0</td>
<td>133</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>All</td>
<td>256</td>
<td>0</td>
<td>0</td>
<td>256</td>
</tr>
</tbody>
</table>

EXCEL PATIENT TRACKING SPREADSHEET
HTTP://IMPACT-UW.ORG/TOOLS/PATIENT.HTML
CONCLUSIONS:

Site Visits before the next reporting is due
QUESTIONS?

• For questions regarding the metrics and reporting:
  marisa.derman@omh.ny.gov

• For questions regarding the Collaborative Care Initiative (technical assistance, webinars, CMTS):
  tjames@institute2000.org
  aheald@uw.edu